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ABSTRACT

This paper provides first-time grant writers with suggestions on how to approach a private funding source. While intended for rural health care advocates, the remarks are equally applicable for educators and others. The rural crisis has produced many heart-rending stories about medically indigent people, but there is a lack of reliable statistics on these people. Faced with a wide range of concerns, grantmakers want to see hard data on the location and nature of the problem in order to judge the validity of the proposed solution. Presentation of an objective case is part of a cooperative attitude which views agency and foundation as partners. Such an attitude is essential for successful grant-writing. Indexes of foundations, grants, and services are available from the Foundation Center; many public libraries carry these. Foundation procedures vary; many have a two step process of a preliminary letter and the full grant application. The project's short- and long-term goals should be stated in a concrete and realistic manner in a preliminary letter. Shortcomings frequently found in rural health care applications include: (1) a lack of community involvement and support; (2) failure to have other funding possibilities; (3) proposal to establish a permanent social service agency (rather than a model demonstration project); (4) assumption of a one-on-one delivery system, making costs prohibitive; and (5) failure to consider networking arrangements to lower costs. (SV)

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FUNDING RURAL HEALTH CARE

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FUNDING RURAL HEALTH CARE

A Pastor friend of mine tells a story about a man in his congregation who dropped a piece of machinery on his foot. The man has limped around for months but has not seen a doctor. He apparently has no access to health care. Will the damage to the foot get better or will there be permanent disability because of the lack of a limited amount of medical care?

Farm crisis counselors tell many stories about phone calls from distraught family members who recognize symptoms of depression but cannot get the family member to take action to get professional help. The mental health centers are open and willing. Yet suicides continue at a pace of 19 per 48,000 in Butler County last year. Is there access to health care?

Most of you in this room have more detailed and more graphic stories to tell about the rural crisis than I have. Some of you may be able to quantify the stories into numbers of people without health insurance in your county, number of unpaid doctor's bills in your community, dollars of uncollectible bills in your local hospital. Let me say that if you can quantify numbers like those you are a rare person in Kansas.

The most startling thing to me since getting involved in grantmaking for our health ministry fund is the absence of reliable information about the effects of the rural crisis on the health care delivery system at the people level. We have some studies about effects on institutions--Congressman Robert's First District Hospital Survey for example. We have a report of the Statewide Health Coordination Council of July 1986 which indicated about 500,000 medically indigent Kansans. But we have limited real information on the location of these persons, their present access or lack thereof, who is serving them and on what basis, etc.

I begin with this because it is an immediate problem for professional grantmakers who have a range of concerns in health care, education, etc. You cannot assume that the people problems dealt with by rural Kansas agencies are going to get grantmakers' attention without data to prove the depth of, the location of and nature of the problem. Without some data on those points, the grantmaker cannot be sure there is a need and cannot be sure your proposal meets the need. Let me say it another way--if a foundation or other private funding source is not predisposed to fund projects in rural health care in Kansas--it is going to rate that problem against others (AIDS, teenage pregnancy, nursing shortage, etc.) and regrettably there are very good statistics in those

areas. The result is that the need in those areas is not based on heart-rending stories but upon significant information which establishes the need on a more scientific basis and the program potential for solving that need.

GOOD HARD INFORMATION ABOUT THE PROBLEM YOU WANT TO SOLVE IS THE FIRST STEP.

My project today is to discuss with you some of the elements of a good approach to a private funding source. For those of you who are professional grantwriters, this is not the right seminar for you; I am only new at this myself and so this is really an introduction for those with programs needing funds who have to approach new and unknown sources.

I started with the statistical problem because it is one which I see in almost all areas we are working. The people who are working on a tough problem like rural health care are convinced it is the most pressing issue in our society; that attitude is the stuff of which great service can be provided, but the failure to recognize the worthy, competing demands which the grantmaker deals with can cause you to fail to state your case in the more objective terms in which the grantmaking society works. The extreme view is that a group will move to an "entitlement" idea in the approach to the grantmaker. This is most likely the worst possible attitude to express. Most grantmakers are not arbitrary and capricious people, but honest fiduciaries seeking to take limited resources and apply them to problems in a constructive manner which produces the "greatest good" from their own perspective. Agencies which believe they have a claim on funds are going to fail to sell their story in an objective way and present the grantmaker with an easy out--an uncooperative agency which already knows more than the community in which it works.

ADOPT THE ATTITUDE THAT YOU ARE LOOKING FOR THE RIGHT PARTNER IN A GRANTMAKER AND EXPECT TO BE TREATED COURTEOUSLY & FAIRLY

If you are looking for a partner you ought to learn what you can about the partner before you approach him. As most of you know, there are lots of resources about grantmaking entities. The Foundation Directory published by the Foundation Center each year lists all foundations of $1 million or more assets or with annual giving of at least $100,000. This book costs $85 a year. The Foundation Center also provides other indexes of grants and services. Resources from the Foundation Center are available in certain designated libraries around the country--The Wichita Public Library is one. Copies of individual private foundations 990-PFs are available through the IRS. Many organizations publish lists of their grants and are happy to provide them.

Clearly, you need not approach foundations which specifically don't do what you are doing. For example, we are limited to health care grants--we will not fund scholarships of any type. Approaching us for scholarships for agriculture students or debtor/creditor arbitration panels is a waste of your and our time. Some foundations will visit with you by phone or letter and give you an indication of their programmatic interests; some won't.

If you have a problem and need funding assistance, are you probably ready to write a grant application? Probably not. The procedures of foundations vary a lot. Many have a two-step process of a "preliminary" letter to determine if the foundation has interest in your organization; the second step is the full grant application. Although the preliminary letter does not require all details to be worked out, a good preliminary letter (approach) still requires a sense of objectives and goals.

A sense of real direction will come through in the preliminary letter. A lack of it will also.

DETERMINE WHAT ARE THE GOALS AND OBJECTIVES FOR THE PROJECT IN THE SHORTTERM AND THE LONGTERM AS SOON AS POSSIBLE. THESE SHOULD BE A CONCRETE AS POSSIBLE (AND REALISTIC).

Let me turn to some specific areas where I am concerned about rural health care applications.

1. FAILURE TO MOBILIZE THE COMMUNITY. The rural care problems are problems facing the entire rural community. One real weakness in many grant applications is the apparent failure to have broad community participation in the approach--many are coming from the very few people engaged in the "hands-on" ministry. You quickly say--you're being unrealistic. Other projects are lead by the "true believers" and you respond to those without the broad, lethargic community being involved. Got me--almost.

A. Community participation in need assessment would strengthen "need" analysis when statistics are weak. Foundations like to help people solve their own problems in ways which appear workable and which have local sanction.

B. Longterm resource solutions have come from the community and the absence of broad community recognition of the problems and commitment to the problem means that such resources are less likely to develop.

C. Absence of broad community participation may make direction and administration less open to change, more self-interested, less responsible.

2. FAILURE TO HAVE SOME OTHER FUNDING POSSIBILITIES. This ties into the first point very directly. Almost all foundations want to participate versus dominate funding. Almost all applications we have received for rural health programs have sought 100% funding from us for the life of the project. In addition to our own getting started identity problems, we recognize, like other funding sources, that a decision to nonrenew 100% funding will be very hard because we will be destroying a program involving employees and clients. Moreover, some foundations have nationwide or statewide programming desires and cannot spend large dollars in one locality and still feel that the programming needs of the total area are met on a reasonable basis. A strong application will have local commitments in hand. It will be pressing forward on other applications. It will seek matching funds, challenge funds, etc.

3. NOT ALL PROJECTS SHOULD LAST FOREVER. Again most grant requests for rural health care we have received have assumed a perpetual nature for the project. Foundations are often reluctant to get into these projects because there will be a continuing need for funding (growing in all likelihood). I think some rural health care projects should start out with a three or five year term, and intend to impact people and make changes in that period. They need to be model projects aimed at showing how things can be done and not permanent social service agencies which may (and hopefully) gradually become irrelevant.

4. PROJECTS SHOULD SEEK TO ANSWER IN INNOVATIVE WAYS. If in doubt throw some money...that is the standard charitable and American answer. Grantmakers, however, are not very inclined to do that. Money is their only alternative in most cases, and they value its ability to change things. One major problem with rural health care grants--stress management, direct health care, etc--is that there is an assumption that this care can be delivered only on a one-on-one basis. This is due to the failure to access services by farmers, particularly, which are readily available. The acceptance of the one-on-one delivery system means almost immediately that the costs are prohibitive. Programs which can work with health care in group settings, (clinics, preventive education, clusters, etc.) will have to be formed. There may never be enough money to deliver health care to every rural front porch, in my opinion. This does not mean that models in other areas which work should not be used--they should.

5. ACCESS TO EXISTING SERVICES. NETWORKING. "Stand alone" rural health care services are going to be difficult to get funding for in this environment of limited resources. Agencies need to work very well with each other. Undoubtedly we need tools to encourage access to existing agencies. We have a study which shows that many people in rural communities had no idea what services were already there. Program applications should assume and work-out the networking arrangements. In some cases, the program may be a referral point which encourages the client out of isolation into the already established social service network.

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These remarks are the personal opinions of the author and are not the official view or opinion of the United Methodist Health Ministry Fund.